CHAPTER 8
SYSTEM ACCOUNTABILITY AND OVERSIGHT

CALIFORNIA'S PUBLIC MENTAL HEALTH SYSTEM

California's public mental health system provides mental health services to persons with serious mental illnesses who have no recourse to services in the private health care sector. Many public mental health clients, through either poverty or the degree of disability caused by their mental illness, qualify for Medi-Cal and receive public services through that funding source. However, county mental health plans are also safety net providers and serve large numbers of persons not eligible for Medi-Cal. In fiscal year 2000-01, the mental health system served over 560,000 clients as shown in Table 1 below. Approximately one-third of the clients served were children and adolescents age 0-17, and slightly more than 5 percent were transition-age youth. Most clients were adults age 22-59. Only 6 percent of the clients were older adults over age 60.

Table 1: Clients Served by the Public Mental Health System by Age in Fiscal Year 2000-01

Age Range	Number	Percent
0 - 17	163,548	29.19%
18 - 21	31,054	5.54%
22 - 59	331,662	59.20%
60 - 64	14,954	2.67%
65 & UP	19,064	3.40%
Unknown	4	0.00%
TOTAL	560,286	100.00%

Substantial public funds are expended on the public mental health system. Table 2 summarizes funding for children's mental health services in fiscal year 2000-01, and Table 3 presents funding for the Adult System of Care in that year. Total funding for mental health services in fiscal year 2000-01 was over $2.2 billion. Expenditures for Children's mental health services of approximately $745 million represented 50 percent of that amount. Of the $2.2 billion in total funding, realignment revenue from sales tax and vehicle license fees totaled $1.1 billion, or 50 percent of the revenue in fiscal year 2000-01.

Table 2: Funding for Children's Mental Health Services for Fiscal Year 2000-01

Program	Funding
State Hospitals	3,400,000
Local Assistance	41,854,000
Managed Care	45,466,000
SAMHSA Block Grant	12,511,000
Early Mental Health Initiative	15,000,000
Special Education Program (AB 3632)	12,334,000
Healthy Families	5,705,000
Early Periodic Screening, Diagnosis, and Treatment	309,632,000
Short-Doyle/Medi-Cal Match[1]	107,364,000
Total DMH	**553,266,000**
Realignment Funds Base[2]	192,216,000
Total Resources for Children's Programs	**$745,482,000**

[1] Does not reflect the Federal Financial Participation for Managed Care Inpatient Services.
[2] Includes $11,396,000 for LPS state hospital beds or other alternatives.

Table 3: Funding for Adult Mental Health Services for Fiscal Year 2000-01

Program	Funding
Local Assistance	102,972,000
Managed Care	136,399,000
SAMHSA Block Grant	23,853,000
Projects for Assistance in Transition from Homelessness	3,850,000
Brain Impaired Adults	12,247,000
Short-Doyle/Medi-Cal Match[1]	295,084,000
Total DMH	**574,405,000**
Realignment Funds Base[2]	921,052,000
Total Resources for Adult Programs	**$1,495,457,000**

[1] Does not reflect the Federal Financial Participation for Managed Care Inpatient Services.
[2] Includes $86,288,000 for LPS state hospital beds or other alternatives.

Table 4, which provides the breakdown of clients' diagnoses for fiscal year 2000-01, reveals the serious nature of the mental illnesses treated by the mental health system. Schizophrenia comprised 12 percent of the diagnoses; bipolar disorder, 9 percent; and depressive disorders, 26 percent. These disorders typically require life-long management, frequently with the continuous use of medications. The diagnoses for children and adolescents in the mental health system are typically ADHD/ADD, conduct disorders, childhood disorders, and adjustment disorders, which together account for approximately 20 percent of the diagnoses.

Table 4: Unduplicated Count of Clients by Diagnosis for All Modes of Service in Fiscal Year 2000-01

Diagnosis	Number	Percent
Schizophrenia	65,515	11.69%
Dementia/Delirium	3,104	0.55%
Anxiety Disorders	23,180	4.14%
Depressive Illness	144,047	25.71%
Bipolar & Mood Disorders	52,375	9.35%
Personality Disorder	2,172	0.39%
ADHD/ADD	25,404	4.53%
Conduct Disorders	27,414	4.89%
Other Childhood Disorders	7,034	1.26%
Substance Abuse Disorder	20,245	3.61%
Adjustment Disorders	50,340	8.98%
Somatoform Disorders	341	0.06%
Dissociative Disorders	17,232	3.08%
Deferred	30,537	5.45%
No Mental Health Disorders	43,393	7.74%
Other Mental Health Diagnosis	46,850	8.36%
Unknown	584	0.10%
Blank	519	0.09%
TOTAL	560,286	100.00%

Because of the ethnic diversity in California, the public mental health system must meet the needs of a very diverse population. As Table 6 illustrates, nearly half the clients served in the mental health system in fiscal year 2000-01 were white; approximately 20 percent, Hispanic; 17 percent, African American; and approximately 6 percent, from Asian/Pacific Islander ethnic groups. Because the concept of mental illness and traditional treatments vary among cultures, providing culturally competent services to clients of such diverse racial and ethnic backgrounds is a major challenge for the

mental health system. Even more difficult is meeting the needs of monolingual clients.

Table 6 also illustrates disparities in access to services among ethnic groups, which is one of the major quality improvement challenges facing the State's mental health system. For example, Hispanics/Latinos are underutilizing mental health services. In the 0-17 age group, they comprise 44 percent of the population but are only 28 percent of that age group of mental health clients. That imbalance is also reflected in the 18-64 age group for Hispanics/Latinos. The data for Asian/Pacific Islanders also reflects a pattern of underutilization. Conversely, African Americans are over-utilizing mental health services. African Americans comprise 6 percent of the total population, but they represent 16 percent of the mental health clients.

EVOLUTION OF OVERSIGHT OF THE PUBLIC MENTAL HEALTH SYSTEM

Because of the magnitude of public expenditures, the serious nature of the mental illnesses, the need of mental health clients for on-going treatment and rehabilitation, and the challenges posed by the ethnic diversity in this State, the State Legislature, at the urging of the mental health advocates and providers of services, adopted a requirement that county mental health programs must collect and report to the Department of Mental Health (DMH) data on the performance of their mental health systems.

In 1991, the Legislature enacted a statute that realigned the funding and program responsibility for mental health services. Previously, the mental health system had been funded from general tax revenues. Because mental health services were not an entitlement, they fared poorly in the State's annual budget process. During the 1980s, the mental health system experienced serious erosion of its funding by not being able to keep up with inflation. It even experienced reductions in state funding during that period. Because of the system's serious fiscal problems, the mental health community was open to changing the funding strategy. The realignment legislation replaced the General Fund revenues with one-quarter cent of the Sales Tax, which was dedicated to county mental health services.

Because sales tax revenues are considered a local revenue source, this funding arrangement dramatically changed the governance of the public mental health system. Prior to realignment, the system had been centralized under the control of the DMH, which allocated funds to county mental health programs and directed the types of services to be provided. After realignment, the DMH's role was more one of providing technical assistance to local programs, managing the state hospitals, and administering the State's Medi-Cal program funding mental health services.

During the development of the realignment legislation, mental health advocates were concerned about the loss of centralized authority over the county mental health program. Realignment gave counties greater autonomy to design their own service systems and greater flexibility in how they spent the funds. Advocates wanted to ensure that a system was in place that held counties accountable for results of their management of local programs. As a result, the realignment legislation included a requirement that county mental health programs had to collect and report to the State performance outcome data on their clients.

Several years after the enactment of realignment and its performance outcome measure requirements, the DMH initiated a major system change: consolidating the Fee-for-Service Medi-Cal system with the Short-Doyle Medi-Cal system and moving the entire Medi-Cal mental health system to managed care. Chapter 7 on managed mental health care describes the evolution of this system. The managed care initiative necessitated that the DMH rethink its approach to oversight of the public mental health system. It issued a series of papers on oversight (California Department of Mental Health, 1998b), (California Department of Mental Health, 1998a).

Requirement To Collect Performance Outcome Data

In the realignment legislation, the DMH was given the responsibility to establish a committee that would specify the outcome measures. In subsequent legislation, the California Mental Health Planning Council (CMHPC) was given the authority to review and approve all outcome measures and to use the

data to review program performance annually. Additionally, the CMHPC is supposed to use the data to identify best practices in providing mental health services so that those services can be replicated in other counties. These statutory provisions are found in the Welfare and Institutions Code (WIC) Section 5772(c).

Mental health boards and commissions (MHBCs) are also given a role in the interpretation of their counties' performance outcome data. WIC Section 5604.2(a)(7) requires that MHBCs review and comment on the performance outcome data and communicate their findings to the CMHPC. The CMHPC developed a workbook format to facilitate this reporting process by MHBCs. Each MHBC received a workbook with that county's performance outcome data. The data were accompanied by a series of questions to assist the MHBC members in interpreting the results for each indicator. The workbook also contained additional demographic and socioeconomic data to assist the MHBCs in understanding the local context for its county's results. MHBCs were encouraged to collaborate with the local mental health program to complete the workbook. Once the CMHPC received all the workbooks, it prepared a statewide report, which by statute was distributed to the Legislature, the DMH, county governing bodies, and MHBCs. The CMHPC anticipates using a similar procedure with future performance outcome data.

In 1999 the DMH established the State Quality Improvement Committee (renamed State Quality Improvement Council in 2002). The purpose of this committee is to identify performance indicators to monitor and to develop special quality improvement studies focused on the Medi-Cal managed care program (California Department of Mental Health, 2001). The enactment of Chapter 93, Statutes of 2000, established the State Quality Improvement Committee (SQIC) in statute. This legislation broadened the SQIC's mandate for quality improvement to include the entire public mental health system and directed the DMH and the SQIC to develop specific types of performance indicators. Members of the SQIC consist of representatives from the DMH, the CMHPC, county mental health directors, consumers, and family members.

The SQIC has established a set of performance indicators drawn from those recommended by the CMHPC. The SQIC prioritized indicators related to access to mental health services as being the most important to study initially. Work began on data related to Medi-Cal beneficiaries using data from the Medi-Cal Paid Claims Files for fiscal year 1998-99 and 1999-2000. In fiscal year 2002-03, the SQIC began to study all clients receiving mental health services using data from the Client and Services Information System for fiscal year 1999-2000. In addition, the SQIC has been conducting special studies related to access to mental health services and in September 2002 released a report studying the increase in the rehospitilization rate between fiscal years 1993-94 and 1999-2000.

Over the years, the system to collect performance outcome data has evolved into a massive undertaking. Up until fiscal year 2002-03, data had been collected annually for all clients who receive services for more than 60 days. This requirement was essentially created through the political process for developing legislation. Its implementation was overseen by a collaboration of representatives from the CMHPC, the DMH, and county mental health programs. Implementation decisions were guided by what the CMHPC believed was necessary for it to provide oversight of the system tempered by the need to have an administratively workable system that was not too burdensome on county mental health programs.

In fiscal year 2001-02, the DMH and its stakeholders began to evaluate the effectiveness of the methodology for collecting performance outcome data. A number of problems had arisen with the way the performance outcome data were collected:

- Inability to develop and operationalize the target population definition
- Failing to measure the greatest amount of change in client outcomes due to delay in the initial measurement
- High levels of attrition over the 12-month data collection window so that second measurements were not obtained on clients to measure their outcomes
- Inability to enforce the data collection requirement

Table 5: 2000 Census Population and Number of Clients in County Mental Health Programs for Fiscal Year 2000-01 by Age and Race/Ethnicity

	TOTAL		0-17		18-64		65+	
	Population	Clients	Population	Clients	Population	Clients	Population	Clients
Hispanic or Latino of any race	10,966,556	115,624	4,050,825	46,129	6,442,962	66,877	472,769	2,618
White alone	15,816,790	255,526	3,222,858	61,040	10,077,793	183,374	2,516,139	11,112
Black alone	2,181,926	93,715	653,820	29,678	1,348,561	62,226	179,545	1,811
American Indian alone	178,984	4,933	49,112	1,656	117,279	3,200	12,593	77
Asian, Pacific Islander alone	3,752,596	34,566	887,553	6,140	2,507,883	26,767	357,160	1,659
Other race	71,681	7,732	24,579	1,521	43,375	5,703	3,727	508
Two or more races	903,115	12,726	361,082	6,092	488,308	6,485	53,725	149
Unknown, not reported	-	36,100	-	10,835	-	24,125	-	1,140
TOTAL	33,871,648	560,922	9,249,829	163,091	21,026,161	378,757	3,595,658	19,074

Table 6: Percent of 2000 Census Population and Clients in County Mental Health Programs for Fiscal Year 2000-01 by Age and Race/Ethnicity

	TOTAL		0-17		18-64		65+	
	Population	Clients	Population	Clients	Population	Clients	Population	Clients
Hispanic or Latino of any race	32.4%	20.6%	43.8%	28.3%	30.6%	17.7%	13.1%	13.7%
White alone	46.7%	45.6%	34.8%	37.4%	47.9%	48.4%	70.0%	58.3%
Black alone	6.4%	16.7%	7.1%	18.2%	6.4%	16.4%	5.0%	9.5%
American Indian alone	0.5%	0.9%	0.5%	1.0%	0.6%	0.8%	0.4%	0.4%
Asian, Pacific Islander alone	11.1%	6.2%	9.6%	3.8%	11.9%	7.1%	9.9%	8.7%
Other race	0.2%	1.4%	0.3%	0.9%	0.2%	1.5%	0.1%	2.7%
Two or more races	2.7%	2.3%	3.9%	3.7%	2.3%	1.7%	1.5%	0.8%
Unknown, not reported	0.0%	6.4%	0.0%	6.6%	0.0%	6.4%	0.0%	6.0%
TOTAL	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Because of these factors, the DMH, in collaboration with the CMHPC and the county mental health directors, has developed a new methodology, which will be implemented in May 2003. Twice a year data would be collected on all clients during a window of a specified length, such as a week or two weeks. These windows would be six months apart. Clients in some treatment settings will likely be excluded from data collection: 24-hour settings (inpatient), crisis stabilization, and linkage and brokerage case management. Based on test runs using data from the Client and Services Information System, this methodology could produce samples for each county amounting to 20-30 percent of clients seen by the county during a fiscal year. This methodology could also yield a subset of approximately 5-10 percent of the clients within this sample for longitudinal analysis, meaning that these clients would be in both the first and second window of measurement so that comparisons could be made of their results over time.

In addition to performance outcome data, the DMH also has the following administration data systems available for system oversight:

- Client and Services Information System
- Cost Reporting/Data Collection System
- Medi-Cal Paid Claims

Chapter 738, Statutes of 1998, (SB 2098, Wright), required the DMH to develop unique client identifiers for its data systems. These identifiers will mean that demographic, service utilization, cost, and performance indicator data for each client can be linked across data sets. Generally, data are available from the DMH's data system 6 to 12 months after the close of the fiscal year.

THEORETICAL PERSPECTIVE ON USE OF PERFORMANCE INDICATORS FOR QUALITY IMPROVEMENT

Performance indicators are evaluative criteria. A set of indicators represents an explicit statement of expectation for the health care delivery system. They are intended to provide useful information relevant to whether their expectations are being met. A performance indicator must be an effective proxy for critical aspects of provider, health plan, or health care system functioning. Performance indicators operationalize evaluative criteria. Each indicator should be a valid and reliable measure that is both sensitive and specific. Indicators should also be effective in distinguishing high and low performers (Sofaer, 1995).

Definitions

The American College of Mental Health Administration (ACMHA), a national organization of mental health clinicians and administrators, has undertaken a project to develop a proposed set of performance indicators that can be used by both public and private behavioral health care providers. As a part of this project, it has developed a taxonomy of terms related to performance indicators (American College of Mental Health Administration, 2001):

- **Domain**: the most global category within which to identify indicators, such as structure, access, process, and outcome
- **Concern**: the most salient issue to be addressed by measurement strategies; describes the desired goal of service provision; e.g., "Clients can access services that they need" states a "concern"
- **Indicator**: something important to measure—the markers that could identify an indicator's target
- **Measure**: the mechanism used or data element identified to support a judgment on an indicator

Performance indicators are divided into four categories by the SQIC: structure, access, process, and outcome (California Department of Mental Health, 2001). Structure is the domain that addresses the resources and tools (human, physical, and organizational) that are needed to provide good quality care. Access addresses how consumers and family members get into care. It relates to the availability of culturally competent services to persons who need them in a manner that facilitates their use. Access includes the degree to which services are quickly and readily obtainable. It also relates to the availability of a wide array of relevant services to meet individual needs (Task Force on a Consumer-Oriented Mental Health Report Card, 1996).

Process is the domain that describes what happens during service provision. The word "appropriateness" is often used interchangeably with process (California Department of Mental Health, 2001). Appropriate services are those that are individualized to address a consumer's strengths and weaknesses, cultural context, service preferences, and recovery goals. Appropriateness of care refers to the best possible match between client's needs and (a) level of care, e.g., inpatient or outpatient, and setting, e.g., psychiatric ward, office, home; (b) the chosen treatment or intervention, e.g., medication or therapy; and (c) service utilization, e.g., length of stay, number of outpatient sessions, and appropriate transitions. Standards for assessing appropriateness are based on the best available efficacy, effectiveness, appropriateness, and quality of care research (Salzer, Nixon, Schut, Karver, & Bickman, 1997).

Two other domains of indicators are outcomes and cost-effectiveness. Outcomes are the domain that investigates the results of services. Outcome is the impact of care on health and well-being, the ultimate goals of providing services. These goals include improvement or stabilization in a client's symptoms and functioning and in client satisfaction with quality of life, health status, and community integration (California Department of Mental Health, 1998b). Cost effectiveness is a domain used by the CMHPC. It is the ability to use resources efficiently to achieve positive outcomes. An example would be using crisis stabilization or crisis residential services instead of acute inpatient hospitalization, if appropriate to a client's needs.

Appendix I to this chapter contains an example of indicator sets for each target population. Measures are included for each type of indicator: structure, access, process, cost-effectiveness, and outcomes. Appendix II contains additional measures that focus on aspects of the cultural competence of mental health services.

Characteristics of Valid Performance Indicator Sets

The process for developing and adopting performance indicators must have normative validity (Sofaer, 1995). When performance indicators have normative validity, all stakeholders would agree that the indicators reflect their shared values about the ideal nature of the mental health system. Selection of performance indicators is inherently value-laden. Different constituency groups bring different norms, values, and priorities to bear on the inclusion of particular indicators and the construction of indicator sets. The statutory role given to the CMHPC to approve performance outcome indicators should assure normative validity because its membership includes all key stakeholders:

- Direct consumers
- Family members
- Advocates
- Local mental health directors
- Community agencies
- Mental health professionals
- State agencies, including the DMH

Lack of Culturally and Linguistically Competent Performance Measures for Ethnic-Specific Populations

However, the values of ethnically diverse groups have not been reflected in the selection of these indicators because of insufficient representation of multicultural and ethnic communities on the CMHPC and other groups involved in the development of performance outcome systems and selection of data collection instruments. The current mental health field is facing major challenges in the development of performance measures that are culturally competent and that are truly relevant in the assessment with multicultural populations. In an effort to move the mental health field towards more effective accountability in mental health treatment interventions, ethnic communities have been left far behind. Several national efforts have been initiated to elucidate the issues and challenges related to mental health treatment for multicultural communities and to developing culturally competent standards. However, these efforts have not resulted in performance outcome indicators and instruments that are relevant and valid for multicultural communities.

Question 18, "I, not staff, decided my treatment goals," from the Mental Health Statistics Improvement Project (MHSIP) Consumer Survey provides an example of how value differences between cultures can affect performance measurement. The Appropriate-

ness/Quality Scale of the MHSIP Consumer Survey from which this question was taken, draws on the Western value of individualism, the assumption that the best way to be is to manage one's own life independently and to make one's own decisions autonomously. The MHSIP Consumer Survey explicitly incorporates concepts important to consumers, such as choice, personhood, and self-management (Teague, Ganju, Hornik, Johnson, & McKinney, 1997).

However, this question would clash with the cultural values of Hispanic or Asian clients, who may have a more interdependent world view. The interdependent worldview is characteristic of cultures in Japan, China, Korea, South Asia, and much of South America and Africa:

> According to this perspective, the self is not and cannot be separate from others and the surrounding social context. The self is interdependent with the surrounding social context and it is the self-in-relation-to-the-other that is focal in individual experience…. The cultural press in this alternative model of the self is not to become separate and autonomous from others but to fit in with others, to fulfill and create obligation, and, in general, to become part of various interpersonal relationships (Markus & Kitayama, 1994).

Clients from these cultures may not be inclined to agree with this question. First, the emphasis on interpersonal relationships in these cultures might incline the clients to place a greater value on the contributions of staff in helping them decide their treatment goals. Second, these cultures also involve their families in health care decisions and the treatment process (Sue, Zane, & Young, 1994) (Murase, 1977). For that reason, they may not even conceptualize the process of recovery or the process of making these decisions as something they do solely by themselves. Consequently, when racial and ethnic groups in the client population being studied do not have meaningful representation in the group of stakeholders developing the performance indicators, there is a substantial risk that the indicators selected may not be relevant or valid for specific racial and ethnic groups.

When developing performance measures, the recognition and inclusion of the culture of the client served must be addressed. Culture fills a pivotal role in the feelings, emotions, and behavior of the individual. Effective communication, treatment planning, and implementation require understanding and engagement between client and provider. Therefore, the performance measures must be culturally competent by incorporating cultural variables throughout. The American Psychological Association supports this issue with the following statement:

> ...the culturally competent psychologist carries the responsibility of combating the damaging effects of racism, prejudice, bias, and oppression in all their forms, including all of the methods we use to understand the populations we serve. It is also clearly recognized the psychology has been traditionally defined by and based upon Western, Eurocentric perspectives and assumptions that have governed the way in which research has been both conceptualized and implemented, including the general tendency to ignore the influence and impact of culture on cognition, emotion, and behavior. Thus, the effects of such biases, have, at times, been detrimental to the diverse needs of the populations we serve and the public interest and have compromised our ability to accurately understand the people that we serve. (Porche-Burke, 1999.)

Multiple mental health strategies used for and by multicultural communities must be evaluated instead of restricting evaluation only to the traditional medical model psychiatric approaches. These solutions must include culturally competent research, researchers, and programs. The field must be willing to move developmentally to challenge old ways of doing things that have not worked for multicultural communities and seek creative new solutions.

Relationship Among Indicators

Selected indicators should carry a great deal of information on important issues. Indicators should be chosen not only because they measure attributes that are important in

themselves, but also because these attributes correlate highly with other important characteristics. Identifying good proxies for system performance requires understanding the relationships between and among health care structures, access, process, and outcomes. A good performance indicator should be backed by empirical evidence of these relationships.

Performance indicators should also possess criterion-related validity (Salzer et al., 1997). Criterion-related validity is "the degree to which services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge" (Institute of Medicine, 1991, p. 1). Criterion-related validity pertains to the extent that structure and process indicators are linked with outcome and outcome indicators are linked to structure and process.

Inferences about the validity of a performance indicator can be drawn from the types of evidence listed below. Stronger inferences can be drawn from methods at the head of the list; weaker inferences from those methods near the end of the list.

- Meta-analyses
- Randomized clinical trials
- Nonrandomized clinical trials
- Expert panel judgment
- Individual practitioner judgment

The majority of indicators in contemporary efforts to develop indicator sets are based on "expert" opinion. Salzer (1997) explains that indicators based on expert opinion have normative validity. However, he cautions the following:

> …normative and consensual validity are weak forms of evidence for making conclusions about criterion-related validity…. This is a reasonable place to begin given the current dismal state of quality of care research, but it must be emphasized that these are unvalidated indicators. Care must be used when discussing results using indicators based on weak forms of inferential evidence (p. 299).

Performance indicators can be referred to as valid when the link between structure, process, and outcome has been established. This approach holds service providers accountable for developing quality service structures and processes that can be expected to produce positive outcomes. This approach is more appropriate than holding service providers responsible for poor outcomes that may have resulted despite high-quality service delivery. The value of a proposed structure or process indicator as a measure of quality is determined by the extent to which it is related to some outcome (Salzer et al., 1997). For example, coordination of services, a structural variable, may be found to be associated significantly with decreased symptoms and increased functioning. Coordination of services would then be viewed as a valid indicator of decreased symptoms and increased functioning. In another example, having bilingual and ethnic providers, a structural variable, may be associated with positive outcomes for multicultural populations.

Using scientific evidence to link performance indicators to outcomes is even more of a challenge when dealing with services to ethnically diverse populations because what studies that have been done on treatment effectiveness have rarely included ethnic populations. The Surgeon General's Supplement on Race, Culture, and Ethnicity states the following:

> Overall, minorities are not represented in studies that evaluate the impact of interventions for major mental disorders. Furthermore, when minorities are included, rarely are analyses conducted to determine whether the treatments are as effective for them as they are for white populations. Although a great deal is known about efficacy of a wide range of interventions for treating common mental disorders, specific information about the efficacy of these interventions for racial and ethnic minority populations is unavailable (p. 172).

The current climate in the mental health field of moving toward evidence-based treatment places at risk once again the relevance of how these approaches will truly meet the needs of multicultural communities. Evidence-based treatment has received strong support as a better way to do business; however, a strong and cautious view should be taken on the populations for which this "evidence-based

treatment approach" is developed. A call for national support for culturally specific evidence-based research is needed along with national support for identification of culturally competent treatment approaches. The Surgeon General's Supplement on Race, Culture, and Ethnicity states the following:

> …the research used to generate professional treatment guidelines for most health and mental health interventions does not include or report large enough samples of racial and ethnic minorities to allow group-specific determinations of efficacy. In the future, evidence from randomized controlled trials that include and identify sizable racial and ethnic minority samples may lead to treatment improvements, which will help clinicians to maximize real-world effectiveness of already-proven psychiatric medications and psychotherapies (p. 160).
>
> No empirical data are yet available as to what the key ingredients of cultural competence are and what influence, if any, they have on clinical outcomes for racial and ethnic minorities…. A common theme across models of cultural competence, however, is that they make treatment effectiveness for a culturally diverse clientele the responsibility of the system, not of the people seeking treatment (p. 36).

Future Direction

New theories and paradigms for quality improvement are continuing to be developed. In fiscal year 2001-02, The SQIC began to explore the work of the Committee on Quality Health Care in America. The Institute of Medicine formed this committee in 1998 to develop a strategy that would substantially improve the quality of health care over the next 10 years (Institute of Medicine, 2001). As a result of its deliberations, the committee published *Crossing the Quality Chasm*, which has stimulated new ways of thinking about quality improvement and accountability.

Crossing the Quality Chasm proposes six aims for quality improvement:

- **Safety**—avoiding injuries to patients from the care that is intended to help them
- **Effectiveness**—providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and overuse, respectively)
- **Patient-centered**—providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions
- **Timeliness**—reducing waits and sometimes harmful delays for both those who receive and those who give care
- **Efficiency**—avoiding waste, including waste of equipment, supplies, ideas, and energy
- **Equity**—providing care that does not vary in quality because of personal characteristics, such as gender, ethnicity, geographic location, and socioeconomic status

The SQIC believes that these six aims of quality improvement can be very useful in generating new performance indicators and in making the public mental health system more accountable and responsive to the needs of clients and their families. Efforts are underway to integrate this new paradigm with the existing "structure, access, process, outcome" method of categorizing performance indicators to produce a smooth transition to a new way of conceptualizing quality improvement in the public mental health system in California. The CMHPC concurs that this new approach is very promising and will work closely with the SQIC to accomplish this task.

CONCEPT OF ACCOUNTABILITY

The main purpose for creating performance indicators was to facilitate oversight of county mental health programs by the DMH, the CMHPC, and local mental health boards and commissions. The intention was also that local mental health programs could monitor their own performance and use the data in their quality improvement processes.

Although performance indicators hold great promise in helping to improve the quality of mental health programs, users of the data must be mindful of their methodological limitations. Much work needs to be done before unambiguous conclusions can be drawn from performance indicators. For example, measurement error and confounding variables affect the kinds of outcomes counties can report. These factors have no relationship to the quality of the services provided. Some of these limitations in interpreting performance outcome data were identified in the first attempts to analyze the data in the early 1990s. For example, the first analyses of the adult performance outcome data, which were collected in fiscal year 1992-93, ranked counties from the best to the worst outcomes on various indicators. However, a cursory analysis revealed the flaw of that approach: some outcome measures are strongly influenced by local conditions. For example, counties with the lowest rate of employment for consumers also had the highest rates of unemployment for their general populations.

These data must be interpreted within their local context taking into account client characteristics, socio-economic conditions, and resources. Risk adjustment is the process for adjusting performance indicators so comparisons among counties can be made. Without such adjustments that take into account differences among counties, direct comparison of counties' results is not possible. Until techniques for risk adjustment are developed, the CMHPC needs to use a different approach for accountability. That approach is to hold counties accountable for their use of the data in their quality improvement processes. Counties can demonstrate their accountability by using performance indicator data in their quality improvement processes. Performance indicator results can be used for a variety of purposes:

- Identifying gaps in the system of care
- Improving the quality of existing services
- Identifying opportunities for great efficiency and more cost-effective services

8.1. Recommendation: Because the performance indicators lack established criterion-related validity, cultural competence characteristics, risk adjustment to compensate for differences among counties, and benchmarks for minimum acceptable performance, the data must be used to describe the performance of the current system. System development should focus on the following actions:

- Assure that the indicator set has face validity and normative validity
- Generate data for each county from existing data systems for the indicators, which will stimulate productive discussions about their implications related to the quality of the service system
- Use local quality improvement systems to explore the relationships between the indicators and to understand variables that influence quality
- Encourage scientific studies to establish the criterion-based validity of the indicator set
- Ensure that local quality improvement systems include performance indicators that are ethnically and linguistically inclusive

ROLE OF CMHPC IN SYSTEM OVERSIGHT AND ACCOUNTABILITY

Section 5772 of the Welfare and Institutions Code (WIC) gives the CMHPC the authority to review, assess, and make recommendations regarding all components of California's mental health system. The statute, which was developed in the early 1990s, makes frequent reference to the term, "performance outcome measure," in describing the CMHPC's mandate. Only in the last few years has the public sector integrated the increased theoretical sophistication of oversight and quality review from the behavioral health care industry and the research literature. The term, "performance outcome measure," has come to refer to one type of performance indicator that measures the results of receiving services on a client's health and well-being. In using the term, "performance outcome measure," the authors of the legislation were referring to the broader class of indicators now understood to include structure, access, and process indicators. Specifically, data recommended to be collected in WIC Section 5612 relates to

structure, access, and process as the examples below illustrate:

- Number of persons in identified target populations served relates to access
- Treatment plan development for members of the target population relates to appropriateness
- Percentage of resources used to serve children and older adults relates to access
- Number of patients' rights advocates and their duties relates to structure
- Quality assurance activities relate to structure

8.2. Recommendation: In keeping with the intention of the statute, references in statute to "performance outcome measures" should be interpreted to mean "performance indicators." The CMHPC should assert its authority to approve all the performance indicators, not just the outcome indicators.

8.3. Recommendation: The CMHPC should continue to consult with the DMH on the development and implementation of current initiatives:

1. Managed care
2. Performance outcome measures
3. The State Quality Improvement Committee
4. The Compliance Advisory Committee
5. The DMH Cultural Competence Advisory Committee

8.4. Recommendation: The CMHPC should monitor the DMH oversight activities, including:

1. Assuring client and family member involvement in oversight activities
2. Reviewing and commenting on various oversight protocols and procedures
3. Assuring that plans of correction from onsite reviews are followed up on
4. Annual reviews of the cultural competence plans

8.5. Recommendation: The CMHPC should assist MHBCs with their oversight responsibilities, including:

1. Determining how to assure that MHBCs are involved in the local quality improvement system
2. Determining how to help MHBCs assess the adequacy of local quality improvement systems

8.6. Recommendation: The CMHPC should ascertain whether local mental health programs are using available data for quality improvement.

ROLE OF MENTAL HEALTH BOARDS AND COMMISSIONS IN SYSTEM OVERSIGHT AND ACCOUNTABILITY

MHBCs have an important role to play in system oversight and accountability. Section 5604.2 of the Welfare and Institutions Code authorizes MHBCs to engage in various oversight activities, such as evaluating the community's mental health needs, services, and facilities; advising the governing body and the local mental health director about the local mental health program; and submitting an annual report to the governing body on the needs and performance of the county's mental health system. In addition, Section 5604 states that the board membership should reflect the ethnic diversity of the client population in the county.

MHBCs are essential partners of the CMHPC in the process of using performance indicator data for system oversight. Particularly relevant is Section 5604.2 (a)(7), which requires that the mental health board review and comment on the county's performance indicator data and communicate its findings to the CMHPC. Because understanding the local context is so central to understanding the performance of a county mental health program, MHBCs have a very important role to play in the process of using performance indicator data to evaluate local programs.

8.7. Recommendation: The CMHPC should provide performance indicator data to MHBCs along with material to assist them in understanding and interpreting the data.

8.8. Recommendation: The CMHPC should also provide a consistent statewide format that MHBCs should use to report their findings to the CMHPC.

8.9. Recommendation: The CMHPC should use the reports from the MHBCs along with its own analysis of the results to prepare reports

to the Legislature, the Department of Mental Health, and other stakeholders about the performance of the public mental health system.

PRINCIPLES TO GUIDE CONTINUED DEVELOPMENT OF OVERSIGHT, ACCOUNTABILITY, AND USE OF DATA

The DMH, the CMHPC, and local mental health programs should adopt the following principles to guide development of oversight and the use of performance indicators:

1. Consumers and family members, reflective of the population served, should be involved in development and implementation of oversight. This involvement can be ensured through the following means:
   - ♦ CMHPC representation on policy development committees
   - ♦ Continued involvement of the Client and Family Member Task Force
   - ♦ Client and family member representation on on-site reviews
2. The oversight paradigm and performance indicators currently in use are derived from national models, such as the American College of Mental Health Administration and the Mental Health Statistics Improvement Project Consumer Oriented Report Card. However, these models are very limited because they do not include ethnic-specific performance indicators. New models should be developed that are inclusive of ethnic, cultural, and linguistic diversity.
3. Data sets have been created for the public mental health system. Stakeholders should master the use and interpretation of these data before developing additional requirements. However, as improved performance indicators are developed for ethnically diverse clients, additional data elements need to be added.
4. Current and future research to determine the key ingredients of clinical practice that make for culturally competent services should be used to assist individuals and programs to provide services to diverse communities. The instruments developed from this urgently needed research should be used as an integral component of a comprehensive plan to develop individual and system cultural competence proficiency.
5. Performance indicators should provide data that are useful to the clinician in assessment and treatment planning and should enable the clinician to assess his or her own effectiveness.
6. When using the data, the DMH and the CMHPC should take an incremental approach to reporting the data. The goal of reporting results for performance indicators is to enable local mental health programs, mental health boards and commissions, and the CMHPC to understand the implications of the data analysis for system performance and improvement. Providing focused reports on aspects of performance rather than comprehensive reports on the entire system will likely result in better use of the data.
7. Ethnic-specific data should be collected to review and track potential disparities by ethnic populations in access to mental health services and quality of care.
8. To improve the cultural competency of oversight activities, the DMH should place high priority on developing proper translations of outcome instruments, obtaining sufficient back translations to produce more valid instruments.

NEXT STEPS IN THE USE OF PERFORMANCE INDICATORS FOR SYSTEM OVERSIGHT

Risk Adjustment

Outcome indicators are influenced by many factors beyond the control of local mental health programs. The purpose of risk adjustment is to isolate the aspects of providing mental health services that are under the control of local mental health programs. To understand the performance of local mental

health programs, the effects of those confounding variables beyond the control of mental health programs must be eliminated. This statistical process is referred to as risk adjustment. Examples of variables to be used for risk adjustment include client characteristics, socioeconomic conditions in each county, and fiscal resources available to fund mental health services. Risk adjustment should facilitate the identification of best practices in the provision of mental health services.

At this point, risk adjustment techniques are highly theoretical and experimental. However, the field of risk adjustment is becoming better defined. For example, payors in the private behavioral health care field are using risk adjustment in provider profiling. Some state governments are using risk-adjusted performance indicators to make decisions about whether to fund specific mental health providers. Key principles for selecting risk adjustment variables are being proposed (Boaz & Dow, 1999), (Hendryx, 1999):

- They should be prognostic indicators of disease course
- They should be substantively related to the outcome
- They should be outside the control of providers to affect through treatment
- They should be able to be measured reliably and validly
- They should account for variance in the outcome indicator (dependent variable)
- They should not interact with the provider groups, i.e., the relationships between risk adjustment variables and dependent variables are consistent across the providers

Once the correct risk adjustment variables have been selected for each performance indicator and their effects on the indicators thoroughly analyzed, the data for each county should be adjusted to the statewide average for the risk adjustment variable under consideration. As risk adjustment analyses become more sophisticated, multivariate risk adjustment techniques should be used so that performance indicators can be adjusted simultaneously for more than one variable.

8.10. Recommendation: The DMH, CMHPC, and California Mental Health Directors Association (CMHDA) need to begin the process of developing risk-adjustment techniques so that the performance of local mental health programs can be compared to the statewide and regional averages.

1. A thorough literature review needs to be conducted to identify the independent variables besides mental health treatment that can affect each performance indicator.
2. The State's databases need to be evaluated to determine whether they contain data on the relevant risk adjustment variables.
3. Data analyses need to be conducted to select the best risk adjustment variables for each outcome measure.
4. County mental health programs need to be involved in the selection and testing of risk adjustment variables to ensure that all the relevant factors that affect their performance are taken into account.
5. Once the risk adjustment variables have been selected and evaluated, each county's outcome data for each indicator need to be risk adjusted to the statewide average to facilitate comparisons with the statewide average and regional averages.

Decision Rules for Evaluating Performance

Risk adjustment is designed to eliminate differences among counties that cannot be attributed to delivery of mental health services. Once that step has been completed, the next logical step is to develop decision rules to identify high and low performers (Kamis-Gould & Hadley, 1996). Comparing results of counties on an indicator to determine which is higher and which is lower is relatively easy. However, whether demonstrated variance means high performance or only a minor difference is not as self-evident. Because behaviors and performance levels vary and fluctuate over time, existing data must be analyzed to decide whether high levels will be determined by quartiles, percentiles, or better

yet, standard deviations above and below the mean.

This approach for developing decision rules advocated by Kamis-Gould (1996) is consistent with the DMH's advocacy in its oversight white paper for "fence posts" or "parameters" for indicators (California Department of Mental Health, 1998b). A multidimensional system of performance indicators requires decision rules that possess the following features:

- Determination of high and low performance on any one indicator (e.g., in terms of standard deviations from the mean)
- Determination of high and low performance on any one domain (e.g., at least two high performance indicators and no low one)
- A decision about whether stability over time should be built-in (i.e., whether some levels should be demonstrated more than once)
- Integration of levels across domains and determination of highs and lows on total performance

Kamis-Gould (1996) provides the following example of decision rules used in New Jersey. New Jersey defines high performance as two standard deviations above the means on at least two performance indicators in at least two domains for two consecutive quarters and no low performance on any one domain. This standard is designed to exclude one-time spikes in performance and to keep highly efficient but ineffective providers from being considered high performers.

8.11. Recommendation: Once the DMH can reliably risk adjust the performance indicators, decision rules should be established to identify high and low performers.

APPENDIX I

INDICATORS FOR SYSTEM OVERSIGHT FOR CHILDREN WITH SERIOUS EMOTIONAL DISTURBANCES[1]

CONTEXT, RISK ADJUSTMENT, OR CASE MIX VARIABLES[2]

INDICATORS FOR CHILDREN	MEASURES	DATA SOURCE
Differences among Counties		
Concern: Differences among counties in resources, socioeconomic conditions, demographics, and client characteristics must be considered before any comparisons of performance indicator results can be made.	**Risk Adjust. 1:** County poverty rate	Statistical Abstract
	Risk Adjust. 2: Per capita funding for mental health services for children age 0-17	DMH and County Fiscal Systems
	Risk Adjust. 3: Degree of ethnic diversity in county population	DOF Population Data

DOMAIN: STRUCTURE

INDICATORS FOR CHILDREN	MEASURES	DATA SOURCE
Staffing		
Concern: Staffing levels and training are appropriate for delivery of the array of services and provide for meeting the diverse needs of the individuals served, including linguistic and cultural competency	**Structure 1:** Number of staff per 1,000 clients by personnel classification	County administration
	Structure 2: Percentage of staff who are bicultural by ethnicity	County Administration Cultural Competency Plans

[1] The intention of the CMHPC is to recommend measures for which data are available. Because the set of instruments for collecting data in the Children's System of Care is in transition, data sources have not been specified for some measures. Modifications will have to be made to these proposed measures once new instruments are selected.

[2] These variables are being introduced for purposes of discussion only.

INDICATORS FOR CHILDREN	MEASURES	DATA SOURCE
	Structure 3: Percentage of staff who are bilingual by language	County Administration Cultural Competency Plans
Continuity of Care		
Concern: The organization has a single, fixed point of responsibility for children and families and provides continuity of care	**Structure 4:** Under consideration	
Coordination of Care		
Concern: The organization provides effective linkages to other service systems with which children and families need to interact	**Structure 5:** Under consideration	
Quality Improvement		
Concern: The organization uses a quality improvement approach to monitoring the performance of its system of care	**Structure 6:** The organization has a quality improvement system in place	On-site reviews
	Structure 7: Counties are measuring children's performance outcomes and submitting the data to the DMH in a timely fashion	DMH Performance Outcome Data System
Rights and Complaint Resolution		
Concern: Consumer rights are clearly defined and procedures for resolution of complaints and grievances are in place and easy to use	**Structure 8:** Number of formal grievances filed by consumers	Not collected
	Structure 9: Number of fair hearings filed by consumers	DMH Ombudsman Office

DOMAIN: ACCESS

INDICATORS FOR CHILDREN	MEASURES	DATA SOURCE
Services Are Reaching the Intended Population		
Concern: Penetration rates demonstrate that services are reaching the intended populations, including culturally and linguistically diverse populations	**Access 1:** Percentage of county population age 0-17 who receive mental health services in one year by modes of service as defined by Client Services and Information System (CSIS), gender, ethnicity, and diagnosis	CSIS
	Access 2: Percentage of the county's monthly average Medi-Cal eligibles age 0-17 who receive mental health services in one year for all aid codes by modes of service, gender, ethnicity, and diagnosis	Medi-Cal Paid Claims
Service Options Available		
Concern: Children and families can access services that they need	**Access 3:** Units of service per client for each mode of service by ethnicity	CSIS
	Access 4: Percentage of resources expended on mental health services provided in the field (natural setting, such as home, school, and work) by ethnicity	CSIS & CR/DC
	Access 5: Percentage of respondents who report that services they need are readily available by ethnicity	YSS & YSS-F Access Score
Cultural and Linguistic Access		
Concern: Children and families have access to a mental health provider who meets their needs in terms of ethnicity, language, and culture	**Access 6:** Percentage of new clients who do not receive a second service within six months of entry in the CSIS reported by ethnicity and language	CSIS

DOMAIN: PROCESS

INDICATORS FOR CHILDREN	MEASURES	DATA SOURCE
Voluntary Participation in Services		
Concern: Children using mental health services do so voluntarily and in collaboration with their families and service providers. The use of involuntary mental health intervention is minimized.	**Process 1:** Percentage of admissions for psychiatric inpatient treatment that are involuntary by ethnicity	CSIS
Services that Maximize Continuity of Care		
Concern: The mental health provider or system maximizes continuity of care	**Process 2:** Percentage of children discharged from inpatient services that receive ambulatory services within 7 days by ethnicity	CSIS
	Process 3: Percentage of children in acute psychiatric inpatient care who have a visit from a case manager while in the hospital by ethnicity	CSIS, but could be difficult to obtain
Minimal Recurrence of Problems		
Concern: Children experiencing an episode of acute psychiatric illness receive care that reduced the likelihood of a recurrence within a short period of time	**Process 4:** Percentage of inpatient readmissions that occur within 30 days of discharge by ethnicity	CSIS
Family and Youth Involvement in Policy Development, Planning, and Quality Assurance Activities		
Concern: Families and youth using mental health services have meaningful involvement in program policy, planning, evaluation, quality assurance, and service delivery	**Process 5:** Percentage of full-time equivalent staff positions that are occupied by family members of children who have received public mental health services by ethnicity	Special Studies
	Process 6: Percentage of youth on mental health boards and commissions and Quality Improvement Committees by ethnicity	Special Studies
	Process 7: Percentage of family members on mental health boards and commissions and Quality Improvement Committees by ethnicity	Special Studies

DOMAIN: COST EFFECTIVENESS

INDICATORS FOR CHILDREN	MEASURES	DATA SOURCE
Scarce Resources Expended Efficiently		
Concern: Use of most restrictive and most costly services is minimized to the extent feasible	**CE 1:** Proportion of total expenditures for services spent on placements in ♦ State hospitals ♦ Group homes ♦ Foster homes ♦ Acute psychiatric hospitals	Various state data systems collected for system of care counties
	CE 2: Number of placements in ♦ State hospitals ♦ Group homes ♦ Foster homes	*State hospitals*: Various state data systems collected for system of care counties *Group homes*: Client Information Sheet I. 6. *Foster Homes*: Client Information Sheet I. 6.
	CE 3: Length of stay in State hospitals for children age 0-17	Various state data systems collected for system of care counties
	CE 4: Number of bed days in acute psychiatric hospitals for children age 0-17	Various state data systems collected for system of care counties

DOMAIN: OUTCOMES

INDICATORS FOR CHILDREN	MEASURES	DATA SOURCE
Living Situation		
Concern: Children and adolescents who are seriously emotionally disturbed should remain in their homes whenever possible or should be placed in the least restrictive, most appropriate, natural environment as close to home as possible	**Outcome 1:** Number of days in each placement during the year by ethnicity	Foster Children: Department of Social Services Special Education Non-public Schools: State Department of Education
	Outcome 2: Living situation reported by percentage of children in each predominant living situation by ethnicity	Client Information Sheet I. 6.
	Outcome 3: Percentage of children in out-of-home placement by ethnicity	Client Information Sheet I. 6.
Concern: Children and adolescents who are seriously emotionally disturbed should be afforded maximum stability in their living situations, moving during the year as few times as possible consistent with their treatment needs	**Outcome 4:** Number of places a child has lived during the last six months by ethnicity	Client Information Sheet I. 6.
	Outcome 5: Subjective satisfaction of children and families with the children's living situation by ethnicity[3]	Not available
Psychological Health		
Concern: The level of psychological distress from symptoms experienced by a child or adolescent is minimized	**Outcome 6:** Percentage of children and adolescents by ethnicity who experience a reliable reduction in psychological distress as reported by the following informants: ♦ Child or adolescent ♦ Parent ♦ Clinician	*Child:* YSS Outcome Score *Parent:* YSS-F Outcome Score
	Outcome 7: Suicide rate among children and adolescents with serious emotional disturbances by ethnicity	CSIS & Vital Statistics, but could be difficult to obtain

[3] The idea is to develop subjective satisfaction scales modeled after those on the CA-QOL and QL-SF.

INDICATORS FOR CHILDREN	MEASURES		DATA SOURCE
	Outcome 8:	Percentage of children and adolescents by ethnicity whose psychological distress improves to the degree that they are no longer in the clinical range as reported by the following informants: ♦ Child or adolescent ♦ Parent ♦ Clinician	Not available
Concern: The level of distress experienced by a family with children or adolescents with serious emotional disturbances is minimized	**Outcome 9:**	Percentage of children and adolescents by ethnicity whose families experience improved functioning or a reduction in family distress	Not available
Physical Health and Safety			
Concern: Children and adolescents who are seriously emotionally disturbed should have an individualized plan of coordinated care that anticipates and addresses their unique and multiple needs, including physical health and need for medication	**Outcome 10:**	Percentage of children and adolescents by ethnicity with serious emotional disturbances whose health is affected by collateral physical health problems who are receiving comprehensive services coordinated between their mental health care and physical health care provider	Not available

INDICATORS FOR CHILDREN	MEASURES		DATA SOURCE
	Outcome 11:	For children and adolescents on psychiatric medication: ♦ Clinician's evaluation of the effectiveness of the medication by ethnicity ♦ Clinician's evaluation of whether they have adequate access to the physician prescribing the medication by ethnicity ♦ Children's evaluation of whether the medication is making them feel better by ethnicity ♦ Parent's evaluation of whether the medication is improving the children's psychological health by ethnicity	First two bullets: County Quality Improvement & Utilization Review Processes
Concern: Children and adolescents who are seriously emotionally disturbed should feel safe in all aspects of their lives	**Outcome 12:**	Children and adolescents' subjective assessment of whether they feel safe in the following environments by ethnicity:[4] ♦ At home ♦ In school ♦ In the community	Not available
Social Involvement and Functioning			
Concern: Children and adolescents who are seriously emotionally disturbed should be supported in developing or maintaining nurturing relationships with their families	**Outcome 13:**	Percentage of children and adolescents who have age-appropriate family relationships by ethnicity	YSS & YSS-F Q 17
Concern: Children and adolescents who are seriously emotionally disturbed should be supported in their efforts to maintain a social support system and engage in meaningful activities, including playing, sports, socializing with peers, and other recreational activities	**Outcome 14:**	Percentage of children and adolescents who have age-appropriate social relationships by ethnicity	YSS & YSS-F Q 18
	Outcome 15:	Percentage of children and adolescents who have age-appropriate interests and activities by ethnicity	Not available

[4] The idea is to develop subjective satisfaction scales modeled after those on the CA-QOL and QL-SF.

INDICATORS FOR CHILDREN	MEASURES		DATA SOURCE
Concern: Children and adolescents who are seriously emotionally disturbed function well in their family and social relationships	**Outcome 16:**	Percentage of children and adolescents who experience a reliable improvement in functioning as reported by the following informants by ethnicity: ♦ Child or adolescent ♦ Parent ♦ Clinician	Not available
	Outcome 17:	Percentage of children and adolescents by ethnicity whose functioning improve to the degree that they are no longer in the clinical range as reported by the following informants: ♦ Child or adolescent ♦ Parent ♦ Clinician	Not available
School Involvement and Functioning			
Concern: Children and adolescents who are seriously emotionally disturbed belong in school so that they may benefit from their educational program and are encouraged to achieve their maximum educational potential	**Outcome 18:**	Percentage of children and adolescents by ethnicity who attend school with the following frequency per week: ♦ Zero ♦ One ♦ Two ♦ Three ♦ Four ♦ Five ♦ Home school	Client Information Sheet IV. B.
	Outcome 19:	For children not being home schooled, average number of days per week they attend school by ethnicity	Client Information Sheet IV. B.
	Outcome 20:	Percentage of children and adolescents who have increased per week school attendance by ethnicity	Client Information Sheet IV. B.
	Outcome 21:	Percentage of children and adolescents in special education by ethnicity	Client Information Sheet. I. 6.
	Outcome 22:	Percentage of children and adolescents by ethnicity who are attending school regularly according to: ♦ The child or adolescent ♦ The parent ♦ The clinician	Client Information Sheet IV. B. from clinician only

INDICATORS FOR CHILDREN	MEASURES		DATA SOURCE
	Outcome 23:	Assessment of academic performance by ethnicity according to: ♦ The child or adolescent ♦ The parent ♦ The clinician	Not available
	Outcome 24:	Subjective satisfaction of the child or adolescent with attending school by ethnicity[5]	Not available
Legal			
Concern: Children and adolescents who are seriously emotionally disturbed should be supported in their efforts to develop and maintain socially responsible behavior, avoid involvement with the juvenile justice system, and remain free of substance abuse and addiction	**Outcome 25:**	Reduction in the percentage of children and adolescents who have a substance abuse problem by ethnicity	CSIS
	Outcome 26:	Reduction in the percentage of children and adolescents involved in the juvenile justice system by ethnicity	Client Information Sheet I. 6
	Outcome 27:	Reduction in the recidivism of children and adolescents involved in the juvenile justice system by ethnicity	Not readily available; collected by juvenile justice system
	Outcome 28:	Reduction in the percentage of children and adolescents engaging in at-risk behaviors, including vandalism, property destruction, and physical assault by ethnicity	Pursue availability from SDE

[5] The idea is to develop subjective satisfaction scales modeled after those on the CA-QOL and QL-SF.

INDICATORS AND MEASURES FOR SYSTEM OVERSIGHT FOR ADULTS WITH SERIOUS MENTAL ILLNESSES

CONTEXT, RISK ADJUSTMENT, OR CASE MIX VARIABLES[6]

INDICATORS FOR ADULTS	MEASURES	DATA SOURCE
Differences among counties		
Concern: Differences among counties in resources, socioeconomic conditions, demographics, and client characteristics must be considered before any comparisons of performance indicator results can be made	**Risk Adjust. 1:** County poverty rate	Statistical Abstract
	Risk Adjust. 2: Per capita funding for mental health services for clients age 18-59	DMH and County Fiscal Systems
	Risk Adjust. 3: Degree of ethnic diversity in county population	DOF Population Data

DOMAIN: STRUCTURE

INDICATORS FOR ADULTS	MEASURES	DATA SOURCE
Staffing		
Concern: Staffing levels, skills, and training are appropriate for meeting the diverse needs of the individuals served, including linguistic and cultural competency	**Structure 1:** Number of staff per 1,000 clients by personnel classification	County Administration
	Structure 2: Percentage of staff who are bicultural by ethnicity	County Administration Cultural Competency Plans
	Structure 3: Percentage of staff who are bilingual by language	County Administration Cultural Competency Plans

[6] These variables are being introduced for purposes of discussion only.

INDICATORS FOR ADULTS	MEASURES	DATA SOURCE
Continuity of Care		
Concern: The organization has a single, fixed point of responsibility for clients and provides continuity of care	**Structure 4:** Under consideration	None identified
Coordination of Care		
Concern: The organization provides effective linkages to other service systems with which consumers need to interact	**Structure 5:** Under consideration	Available only for physical health care from on-site review process
Quality Improvement		
Concern: The organization uses a quality improvement approach to monitor the performance of its system of care	**Structure 6:** The organization has a quality improvement system in place	On-site reviews
	Structure 7: Counties are measuring adult performance outcomes and submitting the data to the DMH in a timely fashion	DMH Performance Outcome Data System
Rights and Complaint Resolution		
Concern: Consumer rights are clearly defined, and procedures for resolution of complaints and grievances are in place and easy to use	**Structure 8:** Number of formal grievances filed by consumers	Not collected
	Structure 9: Number of fair hearings filed by consumers	DMH Ombudsman Office

DOMAIN: ACCESS

INDICATORS FOR ADULTS	MEASURES	DATA SOURCE
Services Are Reaching the Intended Population		
Concern: Penetration rates demonstrate that services are reaching the intended populations, including culturally and linguistically diverse populations	**Access 1:** Percentage of county population ages 18-59 that receive mental health services in one year by modes of service as defined by CSIS, gender, ethnicity, and diagnosis	CSIS
	Access 2: Percentage of the county's monthly average Medi-Cal eligibles ages 18-59 who receive mental health services in one year for all aid codes by modes of service, gender, ethnicity, and diagnosis	Medi-Cal Paid Claims
Quick and Convenient Entry into Services		
Concern: Entry into mental health services is quick, easy, and convenient	**Access 3:** Percentage of respondents who report that the location of services is convenient by ethnicity [7]	MHSIP Consumer Survey Q4
	Access 4: Percentage of respondents who report that services are available at times that are convenient by ethnicity	MHSIP Consumer Survey Q7
	Access 5: Percentage of respondents who report that mental health staff returned their calls within 24 hours by ethnicity	MHSIP Consumer Survey Q6
Range of Service Options Available		
Concern: Clients can access services that they need	**Access 6:** Units of service per client for each mode of service by ethnicity	CSIS
	Access 7: Percentage of resources expended on mental health services provided in the field (natural setting, such as home, school, and work) by ethnicity	CSIS
	Access 8: Percentage of respondents who report that services they need are readily available by ethnicity	MHSIP Consumer Survey Q5 & 8

[7] Positive response to the MHSIP Consumer Survey is operationalized as answering 4 (agree) or 5 (strongly agree).

Cultural and Linguistic Access		
Concern: Clients have access to a primary mental health provider who meets their needs in terms of ethnicity, language, and culture	**Access 9:** Percentage of respondents who report that staff are sensitive to their ethnic culture reported by ethnicity and language	MHSIP Consumer Survey Q13
	Access 10: Percentage of new clients who do not receive a second service within six months of entry in the CSIS reported by ethnicity and language	CSIS

DOMAIN: PROCESS

INDICATORS FOR ADULTS	MEASURES	DATA SOURCE
Voluntary Participation in Services		
Concern: People using mental health services do so voluntarily and in collaboration with service providers. The use of involuntary mental health intervention is minimized	**Process 1:** Percentage of respondents who report actively participating in decisions concerning their treatment by ethnicity and language	MHSIP Consumer Survey Q17 & 18
	Process 2: Percentage of admissions for psychiatric inpatient treatment that are involuntary by ethnicity	CSIS
Services that Promote Recovery		
Concern: The mental health provider or system offers services that promote the process of recovery	**Process 3:** Percentage of Medi-Cal clients by ethnicity for whom medication is prescribed who received prescriptions for: a. Atypical antipsychotics b. Newer generation anti-depressants	CSIS & Medi-Cal Pharmacy Claims Data
	Process 4: Percentage of respondents who report receiving services that support recovery by ethnicity	MHSIP Consumer Survey Q9 & 14
	Process 5: Percentage of respondents who report being involved in self-help activities by ethnicity	MHSIP Q29
Services that Maximize Continuity of Care		
Concern: The mental health provider or system maximizes continuity of care	**Process 6:** Percentage of people discharged from inpatient services that receive ambulatory services within 7 days by ethnicity	CSIS
	Process 7: Percentage of clients in acute psychiatric inpatient care who have a visit from a case manager while in the hospital by ethnicity	CSIS, but could be difficult to obtain
Minimal Recurrence of Problems		
Concern: People experiencing an episode of acute psychiatric illness receive care that reduced the likelihood of a recurrence within a short period of time	**Process 8:** Percentage of inpatient readmissions that occur within 30 days of discharge by ethnicity	CSIS

INDICATORS FOR ADULTS	MEASURES	DATA SOURCE
Consumer Involvement in Policy Development, Planning, and Quality Assurance Activities		
Concern: People using mental health services have meaningful involvement in program policy, planning, evaluation, quality assurance, and service delivery	**Process 9:** Percentage of full-time equivalent staff positions that are occupied by consumers of mental health services by ethnicity	Special Studies
	Process 10: Percentage of mental health consumers on mental health boards and commissions and Quality Improvement Committees by ethnicity	Special Studies
	Process 11: Percentage of family members on mental health boards and commissions and Quality Improvement Committees by ethnicity	Special Studies
Adequate Information to Make Informed Choices		
Concern: Service recipients receive information that enables them to make informed choices about their care	**Process 12:** Percentage of respondents who report receiving adequate information to make informed choices by ethnicity and language	MHSIP Consumer Survey Q11, 16, & 19

DOMAIN: COST EFFECTIVENESS

INDICATORS FOR ADULTS	MEASURES	DATA SOURCE
Scarce Resources Expended Efficiently		
Concern: Use of most restrictive and most costly services is minimized to the extent feasible	**CE 1:** Proportion of total expenditures on services spent on acute inpatient, subacute, and state hospital services	CSIS & CR/DC

DOMAIN: OUTCOMES

INDICATORS FOR ADULTS	MEASURES		DATA SOURCE
Living Situation			
Concern: Persons with mental disabilities have the right to choice, privacy, and independence in their living situation	**Outcome 1:**	Percentage of consumers with serious mental illnesses living in their own house or apartment by ethnicity	CSIS[8]
	Outcome 2:	Percentage of consumers who move to less restrictive settings by ethnicity	CSIS[8]
	Outcome 3:	Percentage of consumers who report being satisfied with their living situation reported by living situation by ethnicity[9]	QOL 2a, b, c
	Outcome 4:	Mean satisfaction with living situation reported by living situation by ethnicity	QOL 2a, b, c
Financial Status			
Concern: Persons with serious mental illnesses should have an adequate income	**Outcome 5:**	Percentage of consumers by ethnicity who are receiving the benefits to which they are entitled	County Universal Method of Determining Ability to Pay Systems
	Outcome 6:	Percentage of consumers by ethnicity who report having enough money for each of these necessities: ♦ Food ♦ Clothing ♦ Housing ♦ Transportation ♦ Social activities	QOL 10
	Outcome 7:	Percentage of consumers who report being satisfied with their finances by ethnicity	QOL 11a, b, c
	Outcome 8:	Mean satisfaction with finances by ethnicity	QOL 11a, b, c

[8] This measure would be analyzed for clients for whom performance outcome data has been collected.

[9] For all outcome indicators, satisfaction is operationalized as answering with categories 5 (mostly satisfied), 6 (pleased), or 7 (delighted) on the instrument.

Productive Daily Activity			
Concern: Persons with serious mental disabilities should have the opportunity to engage in meaningful daily activities, e.g., employment, training, education, etc.	**Outcome 9:**	Percentage of clients with serious mental illnesses involved in competitive employment (part-time or full-time) by ethnicity	CSIS[10]
	Outcome 10:	Percentage of clients with serious mental illnesses involved in volunteer activity by ethnicity	CSIS[10]
	Outcome 11:	Percentage of clients with serious mental illnesses involved in education by ethnicity	CSIS[10]
Symptoms			
Concern: The level of psychological distress from symptoms is minimized	**Outcome 12:**	Percentage of consumers experiencing a decreased level of psychological distress by ethnicity	GAF score, & MHSIP Q26
	Outcome 13:	Suicide rate among persons with serious mental illnesses by ethnicity	CSIS & Vital Statistics, but could be difficult to obtain
Psychological Functioning			
Concern: Service recipients experience increased independent functioning	**Outcome 14:**	Percentage of consumers who report increased functioning by ethnicity	MHSIP Q20-25
Physical Health			
Concern: Mental health services recipients should have good health and equal access (relative to the general population) to effective general health care	**Outcome 15:**	Percentage of Medi-Cal clients who receive mental health services during the year who also received physical health care services through Medi-Cal by ethnicity	CSIS or Medi-Cal Paid Claims & DHS Medi-Cal Data
	Outcome 16:	Mean score on quality of health reported by consumers by ethnicity	QOL 15
	Outcome 17:	Percentage of consumers who report being satisfied with their health by ethnicity	QOL 16a, b, c
	Outcome 18:	Mean satisfaction with health by ethnicity	QOL 16a, b, c

[10] This measure would be analyzed for clients for whom performance outcome data has been collected.

Substance Abuse			
Concern: Clients experience minimal impairment from use of substances	**Outcome 19:**	Rate of all adults receiving services who are identified with substance abuse problems by ethnicity [11]	CSIS[12]
Avoiding Legal Problems			
Concern: Clients should be assisted in their efforts to maintain socially responsible behavior	**Outcome 20:**	Percentage of consumers who report being arrested in the last month by ethnicity	QOL 13
Personal Safety			
Concern: Persons with serious mental disabilities have a right to personal safety and freedom from exploitation	**Outcome 21:**	Percentage of consumers who report being a victim of a violent crime in the past month by ethnicity	QOL 12a
	Outcome 22:	Percentage of consumers who report being a victim of a non-violent crime in the past month by ethnicity	QOL 12b
	Outcome 23:	Percentage of consumers who report being satisfied with their personal safety by ethnicity	QOL 14a, b, c
	Outcome 24:	Mean satisfaction with personal safety by ethnicity	QOL 14a, b, c
Social Support Networks			
Concern: Service recipients experience increased natural supports and social integration	**Outcome 25:**	Percentage of consumers who experience increased activities with family by ethnicity	QOL 4, 5
	Outcome 26:	Percentage of consumers who report being satisfied with their family contact by ethnicity	QOL 6a, b
	Outcome 27:	Mean satisfaction with family contact by ethnicity	QOL 6a, b
	Outcome 28:	Percentage of consumers who experience increased activities with friends, neighbors, or social groups by ethnicity	QOL 7a, b, c, d
	Outcome 29:	Percentage of consumers who report being satisfied with their social relations by ethnicity	QOL 8a, b, c, d
	Outcome 30:	Mean satisfaction with social relations by ethnicity	QOL 8a, b, c, d

[11] As long as under-reporting of substance abuse is a problem, this rate should be compared with the known prevalence rate of dual diagnosis among persons with serious mental illnesses.

[12] This measure would be analyzed for clients for whom performance outcome data has been collected.

INDICATORS FOR SYSTEM OVERSIGHT FOR OLDER ADULTS WITH SERIOUS MENTAL ILLNESSES[13]

CONTEXT, RISK ADJUSTMENT, OR CASE MIX VARIABLES[14]

INDICATORS FOR OLDER ADULTS	MEASURES	DATA SOURCE
Differences among counties		
Concern: Differences among counties in resources, socioeconomic conditions, demographics, and client characteristics must be considered before any comparisons of performance indicator results can be made	**Risk Adjust. 1:** County poverty rate	Statistical Abstract
	Risk Adjust. 2: Per capita funding for mental health services for ages 60 and older	DMH and County Fiscal Systems
	Risk Adjust. 3: Degree of ethnic diversity in county population	DOF Population Data

DOMAIN: STRUCTURE

INDICATORS FOR OLDER ADULTS	MEASURES	DATA SOURCE
Staffing		
Concern: Staffing levels and training are appropriate for delivery of the array of services and provide for meeting the diverse needs of the individuals served, including linguistic and cultural competency	**Structure 1:** Number of staff per 1,000 clients by personnel classification	County Administration
	Structure 2: Percentage of staff who are bicultural by ethnicity	County Administration Cultural Competency Plans

[13] The intention of the CMHPC is to recommend measures for which data are available. Because the set of instruments for collecting data in the Older Adult System of Care is under development, data sources have not been specified for some measures. Modifications will have to be made to these proposed measures once instruments are selected.

[14] These variables are being introduced for purposes of discussion only.

INDICATORS FOR OLDER ADULTS	MEASURES	DATA SOURCE
	Structure 3: Percentage of staff who are bilingual by language	County Administration Cultural Competency Plans
Continuity of Care		
Concern: The organization has a single, fixed point of responsibility for consumers and provides continuity of care	**Structure 4:** Under consideration	None identified
Coordination of Care		
Concern: The organization provides effective linkages to other service systems with which consumers need to interact	**Structure 5:** Under consideration	Available only for physical health care from on-site review process
Quality Improvement		
Concern: The organization uses a quality improvement approach to monitoring the performance of its system of care	**Structure 6:** The organization has a quality improvement system in place	On-site reviews
	Structure 7: Counties are measuring older adult performance outcomes and submitting the data to the DMH in a timely fashion	DMH Performance Outcome Data System
Rights and Complaint Resolution		
Concern: Consumer rights are clearly defined and procedures for resolution of complaints and grievances are in place and easy to use	**Structure 8:** Number of formal grievances filed by consumers	Not collected
	Structure 9: Number of fair hearings filed by consumers	DMH Ombudsman Office

DOMAIN: ACCESS

INDICATORS FOR OLDER ADULTS	MEASURES	DATA SOURCE
Services Are Reaching the Intended Population		
Concern: Penetration rates demonstrate that services are reaching the intended populations, including culturally and linguistically diverse populations	**Access 1:** Percentage of county population ages 60 and older who receive mental health services in one year by modes of service as defined by CSIS, gender, ethnicity, and diagnosis	CSIS
	Access 2: Percentage of the county's monthly average Medi-Cal eligibles ages 60 and older who receive mental health services in one year for all aid codes by modes of service, gender, ethnicity, and diagnosis	Medi-Cal Paid Claims
Quick and Convenient Entry into Services		
Concern: Entry into mental health services is quick, easy, and convenient	**Access 3:** Percentage of respondents for whom the location of services is convenient by ethnicity	MHSIP Consumer Survey Q4
	Access 4: Percentage of respondents for whom services are available at times that are convenient by ethnicity	MHSIP Consumer Survey Q7
	Access 5: Percentage of respondents who report that mental health staff returned their calls within 24 hours by ethnicity	MHSIP Consumer Survey Q6
Range of Service Options		
Concern: Clients can access services that they need	**Access 6:** Units of service per client for each mode of service by ethnicity	CSIS
	Access 7: Percentage of resources expended on mental health services provided in the field (natural setting, such as home, school, and work) by ethnicity	CSIS
	Access 8: Percentage of respondents who report that services they need are readily available by ethnicity	MHSIP Consumer Survey Q5 & 8
Cultural and Linguistic Access		
Concern: Clients have access to a primary mental health provider who meets their needs in terms of ethnicity, language, and culture	**Access 9:** Percentage of respondents who report that staff are sensitive to their ethnicity and culture reported by ethnicity and language	MHSIP Consumer Survey Q13
	Access 10: Percentage of new clients who do not receive a second service within six months of entry in the CSIS reported by ethnicity and language	CSIS

DOMAIN: PROCESS

INDICATORS FOR OLDER ADULTS	MEASURES	DATA SOURCE
Voluntary Participation in Services		
Concern: People using mental health services do so voluntarily and in collaboration with service providers. The use of involuntary mental health intervention is minimized	**Process 1:** Percentage of respondents who report actively participating in decisions concerning their treatment by ethnicity and language	MHSIP Consumer Survey Q17 & 18
	Process 2: Percentage of admissions for psychiatric inpatient treatment that are involuntary by ethnicity	CSIS
Services that Promote Recovery		
Concern: The mental health provider or system offers services that promote the process of recovery	**Process 3:** Percentage of Medi-Cal clients by ethnicity for whom medication is prescribed who received prescriptions for: a. Atypical antipsychotics b. Newer generation anti-depressants	CSIS & Medi-Cal Pharmacy Claims Data
	Process 4: Percentage of respondents who report receiving services that support recovery by ethnicity	MHSIP Consumer Survey Q9 & 14
	Process 5: Percentage of respondents who report being involved in self-help activities by ethnicity	MHSIP Q29
Services that Maximize Continuity of Care		
Concern: The mental health provider or system maximizes continuity of care	**Process 6:** Percentage of people discharged from inpatient services that receive ambulatory services within 7 days by ethnicity	CSIS
	Process 7: Percentage of clients in acute psychiatric inpatient care who have a visit from a case manager while in the hospital by ethnicity	CSIS, but could be difficult to obtain
Minimal Recurrence of Problems		
Concern: People experiencing an episode of acute psychiatric illness receive care that reduced the likelihood of a recurrence within a short period of time	**Process 8:** Percentage of inpatient readmissions that occur within 30 days of discharge by ethnicity	CSIS

INDICATORS FOR OLDER ADULTS	MEASURES		DATA SOURCE
Consumer Involvement in Policy Development, Planning, and Quality Assurance Activities			
Concern: People using mental health services have meaningful involvement in program policy, planning, evaluation, quality assurance, and service delivery	**Process 9:**	Percentage of full-time equivalent staff positions that are occupied by consumers of mental health services age 60 and over by ethnicity	Special Studies
	Process 10:	Percentage of mental health consumers age 60 and over on mental health boards and commissions and Quality Improvement Committees by ethnicity	Special Studies
	Process 11:	Percentage of family members on mental health boards and commissions and Quality Improvement Committees by ethnicity	Special Studies
Adequate Information to Make Informed Choices			
Concern: Service recipients receive information that enables them to make informed choices about their care	**Process 12:**	Percentage of respondents who receive adequate information to make informed choices by ethnicity and language	MHSIP Consumer Survey Q11, 16, & 19

DOMAIN: COST EFFECTIVENESS

INDICATORS FOR OLDER ADULTS	MEASURES		DATA SOURCE
Scarce Resources Expended Efficiently			
Concern: Use of most restrictive and most costly services is minimized to the extent feasible	**CE 1:**	Proportion of total expenditures on services spent on acute inpatient, subacute, and state hospital services	CSIS & CR/DC

DOMAIN: OUTCOMES

INDICATORS FOR OLDER ADULTS	MEASURES	DATA SOURCE
Physical Health		
Concern: Mental health services recipients should have equal access (relative to the general population) to effective general health care	**Outcome 1:** Percent of Medi-Cal clients age 60 and older who receive mental health services during the year that also received physical health care services through Medi-Cal by ethnicity	CSIS & DHS Medi-Cal Data
	Outcome 2: Percentage of consumers who report being satisfied with their health by ethnicity	
Symptoms		
Concern: The level of psychological distress from symptoms is minimized	**Outcome 3:** Percentage of consumers who experience a decreased level of psychological distress by ethnicity	GAF score, & MHSIP Q26
	Outcome 4: Suicide rate among persons with serious mental illnesses by ethnicity	CSIS & Vital Statistics, but could be difficult to obtain
Psychological Functioning		
Concern: Service recipients experience increased independent functioning	**Outcome 5:** Percentage of consumers who report increased functioning by ethnicity	MHSIP Q20-25
Substance Abuse		
Concern: Clients experience minimal impairment from use of substances	**Outcome 6:** Rate of all adults receiving services who are identified with substance abuse problems by ethnicity[15]	CSIS[16]
Productive Daily Activity		
Concern: Persons with serious mental disabilities should have the opportunity to engage in meaningful daily activities, e.g., employment, training, education, etc.	**Outcome 7:** Proportion of older adults with serious mental illnesses involved in competitive employment by ethnicity	CSIS[16]

[15] As long as under-reporting of substance abuse is a problem, this rate should be compared with the known prevalence rate of dual diagnosis among persons with serious mental illnesses.

[16] This data would be analyzed for clients for whom performance outcome data has been collected.

	Outcome 8:	Proportion of older adults with serious mental illnesses involved in volunteer activity by ethnicity	CSIS[17]
Capacity for Independent Community Living			
Concern: Clients function in community settings with optimal independence from formal service systems	**Outcome 9:**	Percentage of older adults with serious mental illnesses living in their own home or apartment by ethnicity	CSIS[17]
Social Support Network			
Concern: Service recipients experience increased natural supports and social integration	**Outcome 10:**	Percentage of consumers who experience increased activities with family, friends, neighbors, or social groups by ethnicity	

[17] This data would be analyzed for clients for whom performance outcome data has been collected.

APPENDIX II

MEASURES TO IMPROVE CULTURAL COMPETENCE OF SYSTEM OVERSIGHT

DOMAIN: PROCESS

TARGET POPULATION	MEASURES	DATA SOURCE
All	Length of service per client for each mode of service by ethnicity	CSIS
All	Retention rate in outpatient services for new client by ethnicity	CSIS
Children	Consumer perception of involvement in treatment planning by ethnicity	Participation in Treatment Scale, YSS, YSS-F
Adults, Older Adults	Consumer perception of involvement in treatment planning by ethnicity	MHSIP Q17-18
Children	Satisfaction with care plan by ethnicity	Appropriateness Scale, YSS, YSS-F
Adults, Older Adults	Satisfaction with care plan by ethnicity	General Satisfaction Scale, MHSIP
Adults, Older Adults	Satisfaction with mental health education and literature by ethnicity	MHSIP Q11 & 19
Children	Satisfaction with cultural sensitivity by ethnicity	Cultural Sensitivity Scale, YSS, YSS-F
Adults, Older Adults	Satisfaction with cultural sensitivity by ethnicity	MHSIP Q13
Children	Satisfaction with linguistic competence by ethnicity	YSS, YSS-F Q14
Children	Satisfaction with range of services by ethnicity	YSS, YSS-F Q10-11
Adults, Older Adults	Satisfaction with range of services by ethnicity	MHSIP Q8
Adults, Older Adults	Attending self-help programs by ethnicity	MHSIP Q29
Adults, Older Adults	Frequency of participation in self-help programs by ethnicity	MHSIP Q30

REFERENCES

American College of Mental Health Administration. (2001). *A proposed consensus set of indicators for behavioral health*. Pittsburgh, PA: American College of Mental Health Administration.

Boaz, T., & Dow, M. G. (1999). *Risk adjusting the Florida outcomes: Relationships among independent variables and dependent variables.* Paper presented at the Mental Health Outcomes Risk-Adjustment: A National Research Development Conference.

California Department of Mental Health. (1998a). *Mental health Medi-Cal managed care oversight*. Sacramento.

California Department of Mental Health. (1998b). *Mental health Medi-Cal managed care oversight discussion paper*. Sacramento.

California Department of Mental Health. (2001). *Establishment of quality indicators for California's public mental health system*. Sacramento: California Department of Mental Health.

Hendryx, M. (1999). *Mental health outcomes risk-adjustment theory: Characteristics of variables and models.* Paper presented at the Mental Health Outcomes Risk-Adjustment: A National Research Development Conference, Spokane, WA.

Institute of Medicine. (1991). *The computer-based patient record: An essential technology for health care*. Washington D.C.: National Academy Press.

Institute of Medicine. (2001). *Crossing the quality chasm*. Washington, D.C.: National Academy Press.

Kamis-Gould, E., & Hadley, T. (1996). *Toolkit: A model of indicators & a report card for assessment of mental health plans' and systems' performance*. Boston: Evaluation Center @ SHERI.

Markus, H. R., & Kitayama, S. (1994). The cultural construction of self and emotion: Implications for social behavior. In H. R. M. S. Kitayama (Ed.), *Emotion and culture* (pp. 89-130). Washington, D. C.: American Psychological Association.

Murase, K. (1977). Minorities: Asian Americans. *Encyclopedia of Social Work, 2*, 953-960.

Salzer, M. S., Nixon, C. T., Schut, L. J., Karver, M. S., & Bickman, L. (1997). Validating quality indicators. *Evaluation Review, 21*(3), 292-309.

Sofaer, S. (1995). *Performance indicators: A commentary from the perspective of an expanded view of health*: The Center for the Advancement of Health

The Western Consortium for Public Health.

Sue, S., Zane, N., & Young, K. (1994). Research on psychotherapy with culturally diverse populations. In A. E. B. S. L. Garfield (Ed.), *Handbook of psychotherapy and behavior change* (4th Edition ed., pp. 783-817). New York: John Wiley & Sons.

Task Force on a Consumer-Oriented Mental Health Report Card. (1996). *The MHSIP consumer-oriented report card.*

Teague, G. B., Ganju, V., Hornik, J., A., Johnson, J. R., & McKinney, J. (1997). The MHSIP mental health report card. *Evaluation Review, 21*(3), 330-341.